

Facility Name & ID Number Parents & Friends of the Specialized Living Center# 0026773 Report Period Beginning: 1-Jan Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>100</u>	Intermediate/DD	<u>100</u>	<u>36,500</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>100</u>	TOTALS	<u>100</u>	<u>36,500</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>29,829</u>			<u>29,829</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>29,829</u>			<u>29,829</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 81.72%

D. How many bed-hold days during this year were paid by Public Aid?

176 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/1982

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided N/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Parents & Friends of the Specialized Living C # 0026773 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	198,299	18,619	8,515	225,433		225,433		225,433			1
2	Food Purchase		157,033		157,033		157,033		157,033			2
3	Housekeeping	124,339	17,901	7,998	150,238		150,238		150,238			3
4	Laundry		968	21,875	22,843		22,843		22,843			4
5	Heat and Other Utilities			117,931	117,931		117,931		117,931			5
6	Maintenance	54,166	9,551	4,016	67,733		67,733		67,733			6
7	Other (specify):*											7
8	TOTAL General Services	376,804	204,072	160,335	741,211		741,211		741,211			8
	B. Health Care and Programs											
9	Medical Director			8,000	8,000		8,000		8,000			9
10	Nursing and Medical Records	1,633,274	35,720	56,958	1,725,952		1,725,952		1,725,952			10
10a	Therapy	19,360			19,360		19,360		19,360			10a
11	Activities	31,966	6,964		38,930		38,930		38,930			11
12	Social Services	22,990		1,440	24,430		24,430		24,430			12
13	Nurse Aide Training	81,836			81,836		81,836		81,836			13
14	Program Transportation		12,091		12,091		12,091		12,091			14
15	Other (specify):*	9,621	1,084		10,705		10,705		10,705			15
16	TOTAL Health Care and Programs	1,799,047	55,859	66,398	1,921,304		1,921,304		1,921,304			16
	C. General Administration											
17	Administrative	69,695		1,355	71,050		71,050	(1,355)	69,695			17
18	Directors Fees											18
19	Professional Services			27,833	27,833		27,833		27,833			19
20	Dues, Fees, Subscriptions & Promotions			21,581	21,581		21,581	(1,627)	19,954			20
21	Clerical & General Office Expenses	95,294	11,513	34,795	141,602		141,602		141,602			21
22	Employee Benefits & Payroll Taxes			428,480	428,480		428,480		428,480			22
23	Inservice Training & Education			3,961	3,961		3,961		3,961			23
24	Travel and Seminar			1,428	1,428		1,428		1,428			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			56,728	56,728		56,728		56,728			26
27	Other (specify):*											27
28	TOTAL General Administration	164,989	11,513	576,161	752,663		752,663	(2,982)	749,681			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,340,840	271,444	802,894	3,415,178		3,415,178	(2,982)	3,412,196			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Parents & Friends of the Specialized Living Center #0026773 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			51,058	51,058		51,058		51,058			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			51,058	51,058		51,058		51,058			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,064	225,064		225,064		225,064			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			225,064	225,064		225,064		225,064			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,340,840	271,444	1,079,016	3,691,300		3,691,300	(2,982)	3,688,318			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Parents & Friends of the Specialized Living Center

0026773

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	1,355	C17		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	1,627	C20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 2,982		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 2,982		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Parents & Friends of the Specialized Living CenterID# 0026773Report Period Beginning: 01/01/2003Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12/31/2003

[illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Parents & Friends of the Specialized Living Center# 0026773Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		H.O.M.E. #2	Fairview Heights	SLC-Enrichment Center	Swansea	To provide recreational opportunities to the severe and profoundly developmentally disabled individuals.
		H.O.M.E. #1	Swansea			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Parents & Friends of the Specialized Living # 0026773 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$		\$			\$		1					
2														2					
3														3					
4														4					
5														5					
	Working Capital																		
6														6					
7														7					
8														8					
9	TOTAL Facility Related							\$		\$			\$		9				
	B. Non-Facility Related*																		
10														10					
11														11					
12														12					
13														13					
14	TOTAL Non-Facility Related							\$		\$			\$		14				
15	TOTALS (line 9+line14)							\$		\$			\$		15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Parents & Friends of the Specialized Living Center**# **0026773** Report Period Beginning: **01/01/2003** Ending: **12/31/2003****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998	8	
	1999	9	
	2000	10	
	2001	11	
	2002	12	
			FOR OHF USE ONLY
			13 FROM R. E. TAX STATEMENT FOR 2002 \$ 13
			14 PLUS APPEAL COST FROM LINE 5 \$ 14
			15 LESS REFUND FROM LINE 6 \$ 15
			16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Parents & Friends of the Specialized Living Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0026773

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,317
 B. General Construction Type:
 Exterior Brick & Frame
 Frame Protected Non-Combustible
 Number of Stories Single Story

C. Does the Operating Entity?
 [X] (a) Own the Facility
 [] (b) Rent from a Related Organization.
 [] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 [X] (a) Own the Equipment
 [] (b) Rent equipment from a Related Organization.
 [] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Specialized Living Center-Enrichment Center -- To provide recreational opportunities to the severe and profound developmentally disabled individuals.

This is a Gymnasium--(with no beds).

Square Footage--7528

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 [] YES
 [] NO
 If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:
 3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care		1979	\$ 999	1
2					2
3	TOTALS			\$ 999	3

Facility Name & ID Number Parents & Friends of the Specialized Living Center

0026773

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1984	1984	\$ 303,400	\$ 10,114	30	\$ 10,114	\$ (1)	\$ 193,001	4
5			1984	1984	33,537		15			33,537	5
6											6
7											7
8											8
	Improvement Type**										
9	Building		1978		17,185		15			17,185	9
10	Various Improvements		1979		18,581		20			18,581	10
11	Metal Heater Guard-All Pods		1981		5,815		15			5,815	11
12	Sport Court		1982		7,239		10			7,239	12
13	Playground Equipment		1982		10,364		10			10,364	13
14	Storage Building		1982		8,927		15			8,927	14
15	Water Heater-Pod 3		1984		2,065		15			2,065	15
16	Draperies-All Pods and Core Building		1984		22,352		10			22,352	16
17	Drainage System		1984		23,286		10			23,286	17
18	Concrete Sport Court		1984		6,564		10			6,564	18
19	Sidewalk-Core Building to ERC		1984		1,900		10			1,900	19
20	ERC Parking Lot		1984		2,176		10			2,176	20
21	Sidewalk-Core Building to Pod 2 & 3		1984		1,050		10			1,050	21
22	Sidewalk-ERC to Maintenance Building		1985		1,632		10			1,632	22
23	Various Trees		1985		5,600		10			5,600	23
24	Parking Lot-Gravel ERC		1985		1,247		10			1,247	24
25	Asphalt Running Track		1985		8,185		10			8,185	25
26	Door/ERC Building		1985		564	19	30	19		344	26
27	ERC Walk & Curb		1985		3,020		10			3,020	27
28	Pine Pavilion		1985		11,542		15			11,542	28
29	Burglar Alarm		1985		868		15			868	29
30	GYM Divider		1985		1,600		5			1,600	30
31	Storage shelves-Gym		1985		1,010		5			1,010	31
32	Central Vacuum System-All Buildings		1985		7,680		10			7,680	32
33	Drapes for Core Building		1985		3,031		10			3,031	33
34	Faucets		1985		2,160	108	20	108		1,944	34
35	Power Mixer Valve-Core Building		1985		561		10			561	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Parents & Friends of the Specialized Living Center

0026773

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Reading Lights-All Pods	1985	\$ 1,689	\$	10	\$	\$	\$ 1,689		37
38	Light Fixtures-All Pods	1985	145		10			145		38
39	Power Panel/Fire Alarm	1985	1,285	64	20	64		1,157		39
40	Bathroom Fixtures-All Pods	1985	2,050		10			2,050		40
41	Fire Alarm System	1986	4,901	245	20	245		4,309		41
42	Windows-Pod Replacement	1986	244		10			244		42
43	Landscaping	1986	892		10			892		43
44	Power Mixer Valve-Core Building	1986	214		10			214		44
45	Bathroom Vanities-All Pods	1986	465		10			465		45
46	Overhead Basketball Goal	1986	3,422		10			3,422		46
47	Draperies-Core Building (Business Office)	1986	254		10			254		47
48	Redo Visitor Room-Core Building	1986	646		10			646		48
49	Light Fixtures-All Pods	1988	1,162		10			1,162		49
50	Heat Booster-Pod 5	1988	712		10			712		50
51	Door Pump/Motor-Core Building Electric Door	1988	858		10			858		51
52	Marble Counter Tops-All Pods	1989	1,818		10			1,818		52
53	Chrome Lava Faucets-All Pods	1989	1,800		10			1,800		53
54	Back Flow Preventor-Core Building (Waterlines)	1989	1,293		10			1,293		54
55	Booster Heater-Pod 7	1989	779		10			779		55
56	New Water Heater-Pod 6 (Booster)	1990	760		10			760		56
57	Repair A/C (Core Building)	1990	2,198		5			2,198		57
58	Repair A/C-Pod 5	1990	1,239		5			1,239		58
59	New A/C-Pod 3	1990	3,525		10			3,525		59
60	New Water Heater-Pod 2	1990	1,522		10			1,522		60
61	New Water Heater-Pod 4 (Booster)	1990	760		10			760		61
62	2 Solid Core Doors-Pod 5	1990	619		10			619		62
63	New Water Heater-Pod 6	1990	820		10			820		63
64	New Water Heater-Pod 7	1991	1,592		10			1,592		64
65	New Water Heater-Pod 3 (Booster)	1991	810		10			810		65
66	Circuit Breaker Box-Core Building	1991	679		10			679		66
67	A/C Unit-Compressor-Pod 2	1991	975		10			975		67
68	A/C Unit-Compressor-Pod 5	1991	1,285		10			1,285		68
69	Fire Safety/Smoke Detectors-All Pods	1991	864		10			864		69
70	TOTAL (lines 4 thru 69)		\$ 555,418	\$ 10,550		\$ 10,550	\$ (1)	\$ 443,863		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 555,418	\$ 10,550		\$ 10,550		\$ 443,863	1
2	A/C Unit-Pod 7 (Unit 2)	1992	3,642		10			3,642	2
3	A/C Unit-Pod 4 (Unit 1)	1992	3,642		10			3,642	3
4	Vanities/Pod Bathrooms-All Pods	1992	3,305		10			3,305	4
5	Rudd Electric Heaters-Pod 2 (Booster)	1992	810		10			810	5
6	Water Heaters-Pod 2 & 4	1993	5,491	183	10	183		5,491	6
7	A/C Unit-Pod 2 (Unit 1)	1993	3,642	243	10	243		3,642	7
8	Windows Pod Replacement	1994	400	40	10	40		397	8
9	Painted All Pods-Labor/Materials	1994	10,644		5			10,644	9
10	Additional Smoke Detectors-All Pods	1994	575	58	10	58		571	10
11	Various Corrections to Code	1994	1,097	110	10	110		1,079	11
12	Rudd Heater-Pod 5 (Booster)	1994	860	86	10	86		846	12
13	Rudd Heater-Pod 6	1995	1,950	195	10	195		1,706	13
14	A/C Unit-Pod 6 (Unit 2)	1995	3,953	395	10	395		3,261	14
15	A/C Unit-ERC (Classroom)	1996	1,774	177	10	177		1,463	15
16	New Carpeting-All Pods	1996	38,806		7			38,806	16
17	Painted Pods/Touch-Up-Labor/Materials	1996	3,356		5			3,356	17
18	Water Heaters-Pod 5	1996	2,032	203	10	203		1,490	18
19	Booster Heater-Pod 5	1996	951	95	10	95		697	19
20	Booster Heater (Spare)	1997	952	95	10	95		729	20
21	Carpeting-Core Building	1997	6,041	863	7	863		5,466	21
22	Water Heater Booster-Dietary	1997	1,585	226	7	226		1,377	22
23	Walk-In Freezer Repair	1998	1,590	227	7	227		1,287	23
24	Water Heater-120 Gallon	1998	2,152	307	7	307		1,562	24
25	Water Heater-120 Gallon	2000	2,256	322	7	322		1,127	25
26	Gymnasium Roof	2000	21,635	1,442	15	1,442		4,447	26
27	Renovation of Pod 2	2001	66,904	9,558	7	9,558		28,674	27
28	Renovation of Pod 4	2001	7,746	1,107	7	1,107		2,491	28
29	Fire Suppression System (Dietary)	2002	2,740	391	7	391		424	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 755,949	\$ 26,873		\$ 26,873		\$ 576,295	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 755,949	\$ 26,873		\$ 26,873	\$	\$ 576,295	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 755,949	\$ 26,873		\$ 26,873	\$	\$ 576,295	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Parents & Friends of the Specialized Living Center # Facility Name & Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2002 Riding Mower	2002	\$ 1,033	\$ 207	\$ 207		5	\$ 344	76
77	Patient Care	2003 Husqvarna Riding Mower	2003	2,577	430	430		4	430	77
78	Patient Care	1993 Ford Van (From Home 2)	2003	16,983				5	16,983	78
79							#VALUE!			79
80	TOTALS			\$ 105,264	\$ 7,214	\$ 7,214	\$ #VALUE!		\$ 90,064	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,300,228	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 51,060	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 51,060	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,050,305	85

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

1. Name of Party Holding Lease: N/A

If NO, see instructions.

Ending

14. /2006 \$

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE <u>44</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE <u>86</u>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	1,454	15,354		16,808
4	Clinical Wages (b)		30,011		30,011
5	In-House Trainer Wages (c)		35,017		35,017
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 1,454	\$ 80,382	\$	\$ 81,836
10	SUM OF line 9, col. 1 and 2 (e)	\$ 81,836			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ N/A

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	48
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	10
2. From other facilities (f)	
TOTAL TRAINED	58

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care	10.3	visits		96	5,851		96	5,851		6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10	Academic Education		hrs								10
11	Exceptional Care Program										11
12											12
13	Other (specify):										13
14	TOTAL			\$	96	\$ 5,851	\$	96	\$ 5,851		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 818,782	\$ 818,782	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	949,929	949,929	3
4	Supply Inventory (priced at <u>Cost</u>)	8,338	8,338	4
5	Short-Term Investments			5
6	Prepaid Insurance	10,445	10,445	6
7	Other Prepaid Expenses	18,276	18,276	7
8	Accounts Receivable (owners or related parties)	74,942	74,942	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,880,712	\$ 1,880,712	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	336,937	336,937	14
15	Leasehold Improvements, at Historical Cost	419,011	419,011	15
16	Equipment, at Historical Cost	619,219	619,219	16
17	Accumulated Depreciation (book methods)	(1,050,305)	(1,050,305)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 324,862	\$ 324,862	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,205,574	\$ 2,205,574	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 37,572	\$ 37,572	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	336,257	336,257	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached</u>	130,198	130,198	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 504,027	\$ 504,027	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 504,027	\$ 504,027	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,701,547	\$ 1,701,547	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,205,574	\$ 2,205,574	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,491,148	1
2	Restatements (describe):	430	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,491,578	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	209,969	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 209,969	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,701,547	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Parents & Friends of the Specialized Living Center # 0026773 Report Period Beginning: 01/01/2003

Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,824,712	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,824,712	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	60,874	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 60,874	23
D. Non-Operating Revenue			
24	Contributions	9,000	24
25	Interest and Other Investment Income***	6,683	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,683	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,901,269	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	741,211	31
32	Health Care	1,921,304	32
33	General Administration	752,663	33
B. Capital Expense			
34	Ownership	51,058	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	225,064	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,691,300	40
41	Income before Income Taxes (line 30 minus line 40)**	209,969	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 209,969	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Parents & Friends of the Specialized Living Center# 0026773Report Period Beginning: 01/01/2003Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,563	\$ 34,509	\$ 20.35	1
2	Assistant Director of Nursing				2
3	Registered Nurses	756	15,125	17.21	3
4	Licensed Practical Nurses	13,346	240,915	16.75	4
5	Nurse Aides & Orderlies				5
6	Nurse Aide Trainees	6,440	46,819	7.27	6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	1,295	19,360	11.65	8
9	Activity Director	1,854	23,236	11.42	9
10	Activity Assistants	996	8,730	8.01	10
11	Social Service Workers	1,871	22,990	10.98	11
12	Dietician				12
13	Food Service Supervisor	3,033	43,793	11.77	13
14	Head Cook	6,535	67,665	9.51	14
15	Cook Helpers/Assistants	797	6,413	7.96	15
16	Dishwashers	9,677	80,428	7.78	16
17	Maintenance Workers	3,904	54,166	12.37	17
18	Housekeepers	13,368	124,339	8.97	18
19	Laundry				19
20	Administrator	1,818	49,990	24.06	20
21	Assistant Administrator	898	19,705	18.04	21
22	Other Administrative	2,681	50,296	15.46	22
23	Office Manager	1,246	27,356	17.17	23
24	Clerical	1,903	17,642	8.50	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	6,908	97,139	12.72	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	122,168	1,241,850	9.26	30
31	Medical Records	356	3,736	10.49	31
32	Other Health Care(specify)	2,037	35,017	15.95	32
33	Other(specify) <u>Seamstress</u>	1,241	9,621	7.37	33
34	TOTAL (lines 1 - 33)	206,691	\$ 2,340,840 *	\$ 10.35	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	169	\$ 7,075	1.3	35
36	Medical Director	96	8,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	82	1,804	10.3	38
39	Pharmacist Consultant	72	1,980	10.3	39
40	Physical Therapy Consultant	103	5,158	10.3	40
41	Occupational Therapy Consultant	206	10,325	10.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	100	6,000	10.3	43
44	Activity Consultant				44
45	Social Service Consultant	24	1,440	12.3	45
46	Other(specify) <u>Psychologist</u>	300	19,297	10.3	46
47	<u>Psychiatrist</u>	48	3,800	10.3	47
48					48
49	TOTAL (lines 35 - 48)	1,200	\$ 64,879		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	98	2,743	10.3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	98	\$ 2,743		53

Facility Name & ID Number Parents & Friends of the Specialized Living Center

0026773

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions		Amount	
Name	Function	%		Description			Description			
Chad M. Rollins	Executive Director	0	\$ 49,990	Workers' Compensation Insurance	\$ 21,774		IDPH License Fee	\$ 200		
Melissa Sauerwein	Assistant Administrator	0	19,705	Unemployment Compensation Insurance	14,861		Advertising: Employee Recruitment	4,869		
				FICA Taxes	172,209		Health Care Worker Background Check (Indicate # of checks performed <u>96</u>)	672		
				Employee Health Insurance	153,267		Illinois Health Care Asso.	5,400		
				Employee Meals	57,777		Less:30.13% Lobbying Costs	(1,627)		
				Illinois Municipal Retirement Fund (IMRF)*			Other Professional Dues	623		
				Employee Gifts	4,234		Belleville News Democrat	120		
				Employee Physicals	4,358		Mgmt. Resource Solutions	9,000		
							Licensing Fees	697		
							Less: Public Relations Expense	()		
							Non-allowable advertising	()		
							Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 69,695	TOTAL (agree to Schedule V, line 22, col.8)		\$ 428,480	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 19,954	
B. Administrative - Other							G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount
Bank Charges			\$ 1,355					Out-of-State Travel		\$
								In-State Travel		
								Seminar Expense		1,428
								Entertainment Expense		()
								(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,355	TOTAL			\$	TOTAL		\$ 1,428
C. Professional Services										
Vendor/Payee	Type		Amount							
Gallop, Johnson, Neuman	Attorneys		\$ 11,233							
Rice, Sullivan and Company	CPA's		6,950							
SIDC	Payroll Service		9,650							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 27,833							

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Asso. \$5400
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,418 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 225,064
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 57,777 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 99%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Rice, Sullivan and Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.